Relief

HISTORICAL SUPPLEMENT TO FOURTH QUARTERLY SANITARY REPORT,
CUMULATIVE REPORT FOR PERIOD OF WORLD WAR II.

Reference: BuMed-E-LG, A2-2/EN10, 10 October 1945.

CHRONOLOGY

The itinerary of the USS RELIEF from 7 December 1941 to 31 August 1945 was as follows:

Port	Arrived	Departed	Days in Port	Days at Sea
Argentia, Newfoundland	10-10-41	12-8-41	59	3
Boston, Massachusetts	12-11-41	12-18-41	7	2
NOB Hampton Roads, Norfolk	12-20-41	1-13-42	24	0
Lynhaven Roads, Virginia	1-13-42	1-13-42	0	1
Norfolk, Virginia	1-14-42	1-31-42	17	0
Navy Yard, Portsmouth	1-31-42	2-18-42	18	0
Wolftrays Degaussing Range, Virginia	2-18-42	2-21-42	3	0
NOB Norfolk, Virginia	2-21-42	3-31-42	38	1
Casco Bay, Maine	4-1-42	2-7-43	312	1
Boston, Massachusetts	2-8-43	2-23-43	15	8
Balboa	3-3-43	3-6-43	3	27
Noumea, New Caledonia	4-2-43	4-26-43	24	3
Espiritu Santo	4-29-43	7-6-43	68	1
Havannah Harbor, Efate	7-7-43	8-3-43	27	0
Fila, Efate	8-3-43	8-4-43	1	1
Espiritu Santo	8-5-43	8-6-43	1	5
Aukland, New Zealand	8-11-43	8-22-43	11	4
Noumea, New Caledonia	8-26-43	10-3-43	38	3
Havannah Harbor, Efate	10-6-43	10-25-43	19	0
Fila, Efate	10-25-43	10-26-43	1	0
Espiritu Santo	10-26-43	10-28-43	2	5
Aukland, New Zealand	11-2-43	11-15-43	13	6
Funafuti, Ellice Islands	11-21-43	11-27-43	6	1
Funafuti, Ellice Islands	11-28-43	1-4-44	37	3
Tarawa	1-7-44	1-31-44	24	3
Kwajalein	2-3-44	2-4-44	1	8
Pearl Harbor	2-12-44	2-14-44	2	7
Roi Island	2-21-44	2-29-44	8	1
Majuro	3-1-44	6-4-44	95	1
Kwajalein	6-5-44	6-15-44	10	1
Eniwetok	6-16-44	6-21-44	5	3
Saipan	6-24-44	6-24-44	0	5
Kwajalein	6-29-44	7-1-44	2	0

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Port	Arrived	Departed	Days in Port	Days at Sea
Eniwetok	7-1-44	7-2-44	1	2
Eniwetok	7-4-44	7-11-44	7	4
Saipan	7-15-44	7-15-44	0	5
Kwajalein	7-20-44	7-21-44	1	4
Saipan	7-25-44	8-4-44	10	4
Eniwetok	8-8-44	8-9-44	1	7
Pearl Harbor	8-16-44	8-25-44	9	9
Eniwetok	9-3-44	9-19-44	16	5
Peleliu	9-24-44	9-30-44	6	11
Noumea	10-11-44	10-15-44	4	12
Pearl Harbor	10-27-44	10-27-44	0	7
San Francisco	11-4-44	2-13-45	101	20
Ulithi	3-5-45	3-26-45	21	1
Guam	3-27-45	3-28-45	1	5
Okinawa	4-2-45	4-10-45	8	5
Saipan	4-15-45	4-16-45	1	2
Ulithi	4-18-45	4-18-45	0	4
Okinawa	4-22-45	4-26-45	4	4
Tinian	4-30-45	5-1-45	1	0
Saipan	5-1-45	5-3-45	2	4
Okinawa	5-7-45	5-10-45	3	4
Guam	5-14-45	5-15-45	1	4
Okinawa	5-19-45	5-26-45	7	4
Guam	5-30-45	6-1-45	2	6
Okinawa	6-7-45	6-11-45	4	4
Saipan	6-15-45	6-21-45	6	5
Okinawa	6-26-45	6-30-45	4	5
Saipan	7-5-45	7-7-45	2	1
Guam	7-8-45	7-9-45	1	4
Leyte	7-13-45	8-25-45	43	0
Guinan, P.I.	8-25-45	8-25-45	0	2
Subic Bay	8-27-45	8-28-45	1	3

Summary of Phases

12-7-41 to 3-3-43: During this period the USS RELIEF was operating in the Atlantic. Three hundred twelve days were spent acting as station hospital at Casco Bay, Maine (4-1-42 to 2-7-43).

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4-4-43 to 1-7-44: The USS RELIEF was engaged in servicing ships of the fleet in the South Pacific.

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1-7-44 to 9-3-44: Central Pacific Phase. The ship evacuated patients from, and provided hospital ship services at, the following named areas; Tarawa, Kwajalein, Majuro, Eniwetok, and Saipan. Three evacuations were made from Saipan. (A total of one thousand seven hundred six patients were evacuated.)

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9-19-44 to 11-3-44: At Peleliu, Noumea, Pearl Harbor - thence to San Francisco. At Peleliu six days during the assault on that island.

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11-3-44 to 2-13-45: Overhaul at San Francisco (General Engineering and Drydock Company at Alameda, California.)

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3-4-45 to 3-26-45: At Ulithi - (Fleet Servicing). It was during this period that casualties from the Kamikaze attack on the USS RANDOLPH were received aboard. A few casualties and survivors from the USS FRANKLIN were also received.

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4-2-45 to 7-7-45: The USS RELIEF made six evacuations from the Okinawa beaches. These casualties were evacuated to the Marianas. Outstanding events during this campaign were a bombing attack on the RELIEF, and evacuation of three thousand six hundred casualties by the RELIEF in six trips in and out of Okinawa.

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7-13-45 to 8-25-45: At Leyte Gulf, Philippines where a bacillary dysentery epidemic served to provide work and patients for the ship up until the time of its departure from that area.

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8-25-45 to 8-31-45: At Guinan, P.I. (Fleet Hospital 114) for disembarkation of patients. The ship then proceeded to Okinawa via Subic Bay, P.I.

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One outstanding event of the ship's wartime service was the evacuation of seven hundred fifty three RAMPs from Dairen, Manchuria on 9-11-45. This has been made the subject of a special report to the Bureau.

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Statistics Concerning Admission Rates:

Year	Total Number of Admissions	Average Admissions per Month
1942	1277	106.42
1943	3028	252.33
1944	5607	467.25
1945 (through Aug. 31st)	4890	407.50
Total for Wartime Period	14802	336.42

Average Number of Admissions per Year.... 4,037

Total Patients for Period 12-7-41 to 12-1-45.... 16,159

Total Number of Patients Evacuated from:

Kwajalein..... 594

Saipan-Tinian(three trips)..1706

Peleliu..... 678

Noumea to U.S..... 499

Okinawa (six trips).....3569

Dairen (RAMPs)..... 743

Guam to U.S..... 383

ORGANIZATION

The USS RELIEF for many years as the sole hospital ship of the U. S. Fleet operated as a unit of the Base Force and from the best information available was so operating at the outbreak of World War II. In 1942 and following a general reorganization of the fleet after the ship's arrival in the Pacific together with the enormous expansion which followed declaration of war the RELIEF operated under ComServPac, ComServron Ten, and various ServDiv Commanders for the greater portion of her Pacific service. On occasions, when service conditions required, the ship operated directly under CinCPac who sometimes assigned her to subordinate Commanders for special duties.

The organization of the medical department of the ship is essentially the same as the organization of the medical department of any ship, with added functions and facilities to suit the requirements. To quote from the ship's organization, "The Senior Medical Officer is the head of the Medical Department. He is responsible to the Commanding Officer for the proper administration of the Medical Department and the proper care of all patients on board." The medical department of a U.S.N. Hospital Ship operates as a department of the ship and not as a medical unit embarked thereon. The head of the medical department is responsible to the Commanding officer.

As of 1935 the personnel of the Medical Department on board the RELIEF was as follows:

Medical Officers.....	10
Hospital Corps Officers.....	3
Dental Officers.....	3
Nurses.....	12(?)
Enlisted Hospital Corpsmen...	115

The Complement, however, was increased later - about 1940 - as follows:

Medical Officers.....	12
Hospital Corps Officers.....	4
Dental Officers.....	4
Nurses.....	12
Enlisted Hospital Corpsmen...	164

NARRATIVE ACCOUNT

At the time of the Japanese attack on Pearl Harbor the USS RELIEF was stationed at Argentia, Newfoundland engaged in servicing units of the fleet in the North Atlantic and in rendering hospital ship service to the local ships and personnel stationed ashore.

On 8 December 1941 orders were received to proceed to Norfolk via Boston. It was at the Norfolk Navy Yard that the ship underwent a general overhaul, remaining in the area slightly in excess of three months. Much was to be done to make her ready for war service. Apparently much enthusiasm prevailed on board prior to departure from Norfolk in anticipation of the active duty so long desired.

From Norfolk the next port of call was Casco Bay, Maine where for 312 long days the ship lay, furnishing hospital facilities for this area during the period of construction of a hospital ashore. From the account of some on board at the time, all hands had despaired of soon rendering service at more forward areas where actual battle casualties would be cared for.

Up to now the RELIEF was painted war gray and was without the customary hospital ship markings as required by international agreement during war. Orders finally were received to proceed to the Pacific via Panama and en route, a call was made at the Boston Navy Yard where the ship was given the distinctive markings of a hospital ship. Also at this time much excess gear and combustible material was landed in preparation for service in battle zones.

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Painted white and showing hospital ship markings specified by international agreements the RELIEF headed south and into the Pacific on 6 March 1943. From Panama a non-stop passage was made to Noumea, New Caledonia where she arrived on April 2nd. The RELIEF provided services for ships in Noumea and Espiritu Santo between April 2nd and July 6th of 1943. The Solomons campaign was in progress at this time. Other ports visited and serviced were Havannah Harbor Efate, Aukland and Funafuti.

The first really serious effects of World War II seen by the personnel of this ship were at Tarawa where a stop of twenty four days was made. The island had already been secured, however air raids were still routine. Kwajalein was the next island from which battle casualties were to be received by this hospital ship - this was on February 3rd of 1944, where fighting was still in progress. One interesting feature of this evacuation was the embarkation of a group of Japanese wounded. The ship evacuated the wounded received at Kwajalein, including the Japanese prisoners, to Pearl Harbor.

After leaving Pearl Harbor and following a short call at Roi the ship proceeded to Majuro where it was engaged in servicing a large concentration of ships for ninety-five days. The Marianas campaign was to commence shortly and the RELIEF sailed from Majuro 4 June 1944 making short calls at Kwajalein and Eniwetok, thence to Saipan arriving on June 24th where the island was under assault. In all, the RELIEF made three evacuations from Saipan. The second evacuation included 276 wounded Japanese nationals; several fatalities as a result of tetanus occurred among the group during the trip to the rear. The third and last evacuation of patients from Saipan was to Pearl Harbor. The ship remained at Pearl Harbor approximately one week, then proceeded to Eniwetok.

The RELIEF resumed routine hospital ship duties at Eniwetok 3 September 1944 and continued these duties until the opening of the Palau campaign. Departing Eniwetok on September 19th, the ship arrived at Peleliu, the island of the Palau group on which the principal assault occurred, on September 24th and remained in this area until September 30th. From Peleliu a large evacuation of patients to Noumea was made. At Noumea patients from Fleet Hospitals No. 105 and No. 107 and certain U. S. Army medical facilities, were embarked for the United States. The ship reached San Francisco, via Pearl Harbor, on November 4th of 1944.

A three months overhaul period at San Francisco was granted. Certain changes in medical department spaces were made during this period. All wards were provided with air cooling facilities. One hundred six semi-permanent bunks were installed on deck, Sick Officers' Quarters capacity increased, central supply facilities installed and other changes made. The RELIEF sailed for Ulithi 13 February 1945 and upon arrival made ready to service a large concentration of ships in this anchorage. The ship remained here until March 26th on which date she proceeded to Okinawa via Guam and arrived at the transport area Okinawa 2 April 1945. The ship was bombed, without damage, by a single Japanese plane on its arrival at Okinawa on the morning of April 2nd. In all, six evacuations were made from the beaches of Okinawa to the Marianas, totaling 3,600 casualties. The last casualties from Okinawa were embarked on June 30th and debarked at Saipan on July 5th.

The duty to follow the Okinawa operation carried the ship to the Philippines - Leyte Gulf. Hospital ship facilities were made available to several hundred ships at this anchorage from July 13th to August 25th of 1945. During this period a most troublesome bacillary dysentery epidemic was underway.

It was at Leyte that the most welcomed news of the Japanese surrender was received. Departing Leyte on August 25th for Guinan, P.I. where all patients were debarked, the ship proceeded to Okinawa via Subic Bay where a twenty-four hour call was made, and arrived at Buckner Bay, Okinawa 1 September 1945.

During periods when the ship lay at anchor in company with combatant ships, hospital ship procedure with respect to illumination at night - quite naturally - was not observed. This situation prevailed quite frequently.

ADDITIONAL DATA

1. Little need be said concerning the citrated blood program which, following its adoption, was so immensely effective. The excellent service rendered at the Blood Distribution Center rivaled the effectiveness of the agent itself. Like many other highly desirable therapeutic agents however, when available in unlimited quantities, some abuses with respect to its use occurred. Despite any abuses however, the restorative qualities of this, oftentimes life saving, agent were dramatic.

2. Gas gangrene in battle casualties remains as a serious problem. It is felt that refrigeration, when possible, greatly reduces general toxicity. Reduced toxicity is directly attributable to the great reduction of metabolic processes in the part and makes possible radical surgery which could not be safely undertaken otherwise. Early and adequate debridement is essential.

3. A word concerning buttocks wounds is perhaps indicated. A number of what appeared to be simple gunshot wounds of the buttocks of several days duration were admitted which subsequently proved to be wounds which had penetrated the abdominal cavity. All cases of gunshot wounds of the buttocks should be regarded with suspicion as to possible abdominal injury.

4. While it is not intended to damn the hospital transports by faint praise, because they did render invaluable service, it is believed that patients which must eventually be received on board hospital ships should be transferred directly to the hospital ships with the least possible delay. It so frequently happened that casualties from the beaches were first sent on board the hospital transports, later to be sent to the hospital ships. It seems that much loose motion could be avoided by the transfer of such patients directly to the hospital ships when and if present.

5. In regard to the treatment of burns it may be said that nothing of exceptional note regarding new methods of treatment was developed on board the RELIEF. Citrated blood and plasma in adequate quantities resulted in the already recognized benefits which may be expected from such therapy. Aseptic technique in carefully applied compression dressings left undisturbed for as long as possible

certainly had its merits. The consensus of opinion of the Staff of this hospital ship is to the effect that the answer for the treatment of burns is not yet uncovered and much remains to be learned concerning the chemistry involved.

6. While it is recognized that perfection in such matters is impossible of attainment, nevertheless it remains a fact that the best judgment in the matter of calling up hospital ships to the forward areas was not always used. It did frequently happen that as many as three hospital ships were in the same combat area at the same time with few if any patients for any one of them. More attention should be given to this matter - by close cooperation with those in authority - as to when offensive action, with an expected increase in casualties, might occur. Hospital ships are without means of self protection and should not be required to remain in active combat zones longer than is necessary. A carefully planned program of staggering in calling up hospital ships by those who are familiar with the situation could obviate this difficulty.

The Medical Service, during the Okinawa campaign, was charged with the responsibility and care of patients with chest wounds, excluding those with combined abdomino-thoracic wounds and hollow-viscus injury. Approximately one hundred fifty such cases were treated, one death occurred. Clinical statistical analyses were made of one hundred ten of these chest cases; the following data were obtained:

58 were wounded by shell fragments.

52 were wounded by bullets.

89 had penetrating chest wounds.

31 had non-penetrating chest wounds.

56 of the 89 penetrating wounds had retained foreign metallic bodies, the majority (49) being shell fragments.

Of these 56, there were 29 instances of metallic foreign body imbedded in the lungs, 25 in the chest wall, 6 in the pleural cavity, and 14 within the abdomen. (A number of these patients had more than one foreign body).

30 patients had associated fracture of one or more ribs, 5 had fracture of the clavicle, 5 fracture of the scapula,

and 4 with fracture of the spine and transection of the spinal cord in the dorsal region.

83 of the penetrating wounds produced hemothorax, and in 14 cases there was significant pneumothorax.

19 cases showed appreciable shift of the mediastinum, but in only 6 was there clear evidence of tension pneumothorax.

37 of the penetrating wounds were sucking in character, this was usually transient or corrected surgically soon after wounding. Of this group, only 2 developed tension pneumothorax after admission, and only 12 showed unmistakable evidence of mediastinal shift.

The majority of the total cases had received some treatment prior to admission - usually debridement and closure and blood and plasma transfusion. The average number of days elapsing between wounding and admission was 4.5 days. It varied with conditions ashore, and ranged between one day or less (26 cases) to 21 days (1 case). At least 66 of the total cases had received blood or plasma or both. After admission additional blood was given to 65 cases, and plasma to 34. The amounts ranged from 500 cc. to 4,000 cc. per patient, with an average of approximately 1,000 cc. In the management of these cases blood and plasma played a most important role. In many instances it was life-saving, in many others it undoubtedly shortened the period of morbidity and convalescence.

Aspiration of the blood from the pleural cavity was another major factor in treatment. It was performed early only in those cases requiring immediate relief from respiratory embarrassment. It was usually performed 48 or more hours after wounding. Of the 83 cases with hemothorax, thoracentesis was performed in 54, an average of 2.3 times per patient. The performance of thoracentesis was usually done for the purpose of allowing the lung to re-expand and to reduce the possibility of clotting and fibrin deposition. It is considered to be good therapy.

Oxygen inhalation by mask was used in those instances where patients showed respiratory difficulty. Its use was considered necessary in probably one-third of the penetrating wounds, during the first few days. It often lessened pleural pain and resulted in a more effortless respiration.

Penicillin and sulfonamides were highly effective in prevention of infections and complications, as well as in their treatment.

In those cases, a minority, where debridement and closure of the wound had not been done ashore, it was usually done on board within the first few days.

There were relatively few complications which developed during the comparatively short time these patients were aboard. (The time aboard was usually about 7 to 10 days). A partial list of the complications which were present on admission is:

Empyema with infected wounds.....6
Paraplegia due to transection of
spinal cord.....4
Brachial plexus laceration and
paralysis.....8
Bilateral.....1
Hemopericardium.....1
Femoral thrombophlebitis.....1

In addition, two cases developed empyema after their admission. It is not known how many additional complications developed after these patients were delivered to the rear base hospitals, but it is believed that the number is not large.

Treatment of gunshot wounds of the chest should where possible be the joint responsibility of the Medical and Surgical Services.

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The Medical Service's experience with bacillary dysentery in Leyte Gulf was of some interest. From a diagnostic standpoint no great difficulty was encountered. A simple gross inspection of the stool was often sufficient, and microscopic examination of the stool was usually conclusive. Stool cultures were done in a large number of cases and Flexner bacilli were recovered in about 60% of the cases where a single culture was made. Laboratory facilities on board were not adequate to do routine cultures and repeated cultures where large numbers of patients were being received.

The use of sulfadiazine in treatment was highly satisfactory, although a small minority of the patients were slow in showing a satisfactory response. In some of these, the changing to sulfaguanadine produced satisfactory responses. This drug was valuable in those few patients showing sensitization to sulfadiazine. However, on the whole sulfaguanadine was less effective than sulfadiazine. Although the response to these sulfonamides was not always as prompt as was desired, they undoubtedly reduced the morbidity days, and the stool cultures became negative sooner than would otherwise have been possible.

A word of caution is considered appropriate in regard to maintaining an adequate fluid balance in cases of dysentery receiving sulfa-drugs. Intravenous fluids were given in every case during the first few days of treatment in order to assure this, and there were no cases of renal injury developing on this ship. Admitted however, were several such cases after its development, and two of these

terminated fatally.

Dysentery is a serious problem aboard ship. Sporadic cases continued to be admitted for several months after the ship had left the epidemic area.

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During the past year a few cases of acute infectious jaundice were admitted. These were in the main mild or moderately severe cases which recovered in two or three weeks. There were no deaths or serious complications. The treatment was that generally employed, with the exception that several units of plasma were administered to each patient on the basis that there might be some antibody effect and that benefit might be obtained by supplementing the protein production of the liver. Results were inconclusive. Intravenous glucose was given over a longer period of time than is usual. In fact, an attempt was made to give a full and meticulous treatment even when the case was mild and ambulatory, hoping that by so doing the disease might be promptly arrested. Whether this was accomplished is not possible to determine, as no controls, etc., were used.

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<u>Gas Gangrene</u> as encountered in the Marianas, Peleliu and Okinawa Operations:

Gas gangrene treated aboard this ship almost without exception was secondary to an ischemia. Primary infection due to the clostridium group without definite circulatory inefficiency was, if present in any case, exceptional.

The causes of the ischemias fell into the following fairly definite groups:

1. Major vessel damage.
    a. Severance of the vessel by high explosive fragments.
    b. Severance of the vessel or compression of it by compound fracture of the long bones.
    c. Compression of the vessel by massive enclosed hemorrhage.
    d. Circulatory inefficiency caused by arterial hematoma or early arterio-venous fistulae.
2. Ischemias caused by casts.
    a. Secondary swelling after the application of the cast.
    b. Changes in position of fractures after the application of the cast with consequent development of pressure areas.
    c. Secondary hemorrhage imprisoned in the tissues by the casts and dressings.

3. Ischemias caused by packing.
   a. Tight packs inserted into the tissues to control hemorrhage but which too often merely converted an external into an internal hemorrhage thus adding to the circulatory inefficiency.
   b. Narrow packs inserted into small wounds which then acted as plugs which interfered with the circulation locally and allowed no external escape for secondary hemorrhage.
   c. The use of a pack plus a tourniquet when the latter would have sufficed. The pack again had concealed secondary hemorrhage occurring with periodic removal of the tourniquet with the consequent local increase of tissue tension.

The clinical course in these patients was never as rapid nor as dramatic as it is in the so-called primary clostridium infections. The sudden onset of overwhelming toxicity was usually not present. The clinical and laboratory findings were otherwise typical of gas bacillus infections.

All cases received penicillin, the sulfonamides, plasma and whole blood in adequate quantities. Only a few commonplace conclusions may be drawn as to the value of the therapy. On one of the Surgical Services serum was used in therapeutic doses up to 120,000 units. On the other service no serum was used. No appreciable difference in the end results were noted. In those cases in which conservative incision and excision of the involved parts was performed subsequent radical treatment (amputation) was usually required.

Reamputation at higher levels was never required and this may be attributed either to the lack of virulence of the organism or that its virulence was attenuated by the chemo-therapy. From previous experiences the latter would seem to be a justifiable conclusion. In support of this it should be mentioned that in all cases the post-operative wounds remained clean and healthy despite the fact that the patients' general condition was frequently poor due to the rigors of battle, multiple wounds, etc.

In conclusion it is felt that certain preventive measures might be of value in the prevention of gas gangrene:
(1) Brisk hemorrhage which can not be controlled at the time by effective operative procedure should be controlled by a tourniquet.
(2) Packing should never be used to control true hemorrhage for more than minutes at a time.
(3) The virulence of the infecting clostridium organism must be judged by the clinical picture and this may vary from an overwhelming toxicity to a very mild one. With this in view, despite all the classical clinical findings, time may be taken for adequate pre-operative preparation of the patient and in certain cases less radical surgical procedures may at least be attempted with a view to augmenting them later if necessary.

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CONCLUSIONS

1. No serious operating difficulties were encountered on board this hospital ship during the period covered by this report.

2. With the addition of a number of hospital ships to the fleet during the war the need for a hospital ship organization and procedure which would be standard for all such ships is apparent. To operate the medical department of a hospital ship along the lines of the medical department of an ordinary ship is not practical. The Senior Medical Officer should be given the status of the officer in command of a medical unit embarked, and with it absolute authority as to how personnel of such unit be assigned. Navy Regulations Paragraph 121 does not provide sufficient authority in this matter. Generally speaking the Senior Medical Officer occupies a position, with respect to subordination, too low as to be commensurate with his responsibilities.

3. The question of the assignment of Nurses on board hospital ships for duty far removed from the continental USA, and particularly in combat zones, has been presented before and is, no doubt, not a popular subject to open. The presence of nurses is unquestionably desirable. However the disadvantages - in the opinion of this writer - outweigh the advantages.

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4. Experienced and relatively senior medical officers assigned to the staffs of Task Force Commanders and Group Commanders who actually control the movements and operations of hospital ships at the combat areas would probably add to hospital ship operating efficiency.

5. The question as to the undesirability of friendly aircraft closely approaching hospital ships in combat zones - except for purposes of identification - has been made the subject of a special report.